OON Medical Records Cover Sheet (Use One per Patient)

PRACTITIONER NAME: TIN #____________________

PRACTITIONER ADDRESS:

Practitioner Phone#:________________

Practitioner FAX #:_________________

(Providing your FAX # will expedite the response to this request)

*NPI # (Type 1-Ind)*________________________ *NPI # (Type 2-Org)*____________________________

To: American Specialty Health	Date:
Fax: Within CA ONLY: 1.877.427.4777 Outside of CA: 1.877.304.2746	Pages:
Patient Name: Pt. Birth date:	Patient ID#: Gender: ☐ Male ☐ Female
Subscriber Name: Subscriber ID#:	Health Plan: Group #:

TREATMENT / SERVICES SUBMITTING FOR REVIEW

Diagnoses (ICD Code): 1.__________________ 3.______________________

2.__________________ 4.______________________

Date Range: From ____/____/_______ Through ____/____/_______

# of E & M Services: ☐ New Pt. Exams ☐ Est. Pt. Exams

# of Visits (Includes 98940-98943 Codes) during date range: ☐

Are you requesting review for Extraspinal CMT services (98943)? ☐ Yes

# of Modalities/Procedures (97000-97545) during date range: ☐

List Modalities/Procedures (by CPT):_______________________________________

OTHER SERVICES WITHIN THE ABOVE DATE RANGE YOU ARE SUBMITTING FOR REVIEW:

Durable Medical Equipment by HCPCS Code(s):________________________ Date:__________

Consultation/Preventive Services by CPT Code(s):____________________ Date:__________

Prolonged/Special Services by CPT Code(s):_________________________ Date:__________

Electrodx. &/or Lab studies by CPT Codes(s):________________________ Date:__________

Imaging / Other Studies by CPT Code(s):____________________________ Date:__________

Other Services by CPT/HCPCS Code(s):_____________________________ Date:__________

By submitting this *Medical Records Cover Sheet,* I attest that the above dates and services are those I wish to have reviewed for medical necessity.

Please attach all relevant Exam Forms, Clinical Notes or Reports that support the medical necessity of the submitted services.